WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis

PUBLIC INPUT
April 6, 2006

Introduction

The current report represents an analysis of the content of public testimony related to the Washington State Mental Health Transformation (MHT) effort. The report provides a summary of statements received by the state MHT team. These pieces of information include public comments received via email, fax, web survey, or handwritten statements, and also relevant feedback submitted from entire agencies or organizations, some of which engaged in their own group processes before compiling and submitting their input.

Method

Across the many sources of data listed above, information received and analyzed typically were responses to a consistent set of 4 open-ended questions posed to individuals statewide:

1. Within Washington State, and for all mental health services, public or private, what is working well when addressing the needs of mental health consumers?
2. Within Washington State, and for all mental health services, public or private, what is NOT working, creates barriers or fails to provide quality service and support when addressing the needs of mental health consumers?
3. What would a "transformed" mental health system look like?
4. What outcomes would indicate that the changes in the mental health service systems are creating improved results for consumers?

Data were received from the state MHT team in the form of reports from agencies or programs, emails and web surveys forwarded from public constituents, and Adobe Acrobat “PDF” files of handwritten testimony. A team of PhD-level researchers then conducted qualitative analysis of these raw data using a technique described by Marshall & Rossman (1989). First, unique statements were isolated and summarized from all individual testimonials received. Next, categories were created and all statements sorted by these categories. Third, new categories were created for statements that did not fit the initial categories. Finally, small categories were sorted into primary categories.

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To increase ease of use and interpretation, a single analysis of all statements was conducted. However, this report also includes a Table with responses broken out by all four questions. The purpose of the report is to provide those working on the MHT project a record of all the public feedback received, organized in a way that allows for observation of the relative amount of testimony provided within each topic area, and discussion of priorities for action.

The current report

The current report consists of three main sections.

- The first section presents an **overview** of the analysis, including data sources and total number of unique statements coded. This section also includes a brief narrative summary of the findings.
- The second section presents the **results of qualitative analysis in detail**. This Table presents unique themes expressed in public testimony for each of the 4 Mental Health Transformation questions, organized by primary and secondary categories. For each unique theme, the number of statements that were found in the data related to that theme is presented. It is hoped that this Table will be a useful reference for the Subcommittee as it reviews the priorities presented by the public for action.
- The third section presents a selection of **direct statements and quotes** from the meeting transcripts and other information received, grouped by major themes.

Acknowledgments

Data analysis for the Mental Health Transformation Public Testimony Summary and Analysis Reports was conducted by:

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Data sources:

1. Handwritten Statements in "PDF" format
2. Web Surveys
3. Faxes
4. Emails
5. Other forms submitted to the MHT team for analysis.

Total Statements coded = 2261

Summary of findings

Individual public testimony covering all populations in the mental health system consisted of 2261 unique statements coded from 248 individual sources of input. Raw data included submissions of testimony via hand-written submission, email, fax, as well as additional documents received from agencies and organizations that could not be present at specific Sub-committee meetings or other public hearings.

Three hundred and thirty-five statements were coded from responses to the question "What is working well," 751 statements were coded from responses to the question "What is not working well," 821 statements were related to the question about what a transformed system will look like, and 354 comments were coded regarding proposed outcomes of a transformed mental health system.

A brief summary of the results across the four questions is provided below:

- **Funding** in general was noted many times by consumers and providers. A general lack of funding exists in the mental health system. Providers do not have the funding to meet the needs of the consumers and many consumers in need do not qualify for Medicaid and do not have the ability to pay for services. Inflexibility is a key funding issue for consumers and providers. Consumers' treatment is often dictated by what funding they have rather than what treatment they need, while providers are forced to only provide treatment to those who qualify for that program's services and not based on the needs of the consumer. A transformed system would have more flexible funding options and the funding would follow the consumer not be restricted to the programs and services.

- **Medicaid funding** was a major topic of discussion. The system is works better for individuals who qualify for Medicaid, but the eligibility requirements for Medicaid are viewed as being too strict, which makes access for other consumers very difficult. Access to care for non-Medicaid eligible consumers is one of the major issues of the current system. One remedy suggested is to make access easier by having more flexible funding sources other than Medicaid.

- **Access to care** in general was noted as a barrier to care in the current system. Access for non-Medicaid and non-private pay, access to appropriate medications, access to a psychiatrist or other doctoral level therapist, and access to services in rural areas were the most mentioned. If a person does manage to qualify for services, receiving timely treatment was often difficult. The time from referral to assessment and then to treatment itself are often lengthy. For those who cannot access the system or those who do not receive timely treatment, the only option is often primary care physicians or the ER. This costs a lot of money and providers are not trained to handle mental health in these facilities, so need for treatment often is often supplanted with crisis de-escalation without follow-up or referral leading to a return to the ER. One major comment about access from is that there is never enough resources to meet the demands, thus, service providers are forced to turn away many people who are not in crisis. Consumers commented that crisis care was readily available but that follow-up often was not due to lack of resources.

- Providers and consumers alike mentioned that the system currently has too much **bureaucracy**, **unmanageable paperwork** requirements, and **too many regulations** that are constantly changing and often conflicting. Providers say that paperwork requirements cause them to spend less time with clients because of the time it takes to complete paperwork. Consumers also said that the paperwork at intake and when transferred to other programs was excessive. Consumers often opted out of services before they even began once they saw the amount of paperwork required to get in to the system. An MIS system for providers to share client information, a uniform policy and regulatory system, as well as less restriction on client privacy were all mentioned as ways to remedy this issue in the transformed system.

- **Integration and Collaboration** of services and between individual professionals was noted as not being done efficiently or often and was noted as a key component of a transformed system. Transfers and referrals were often not smooth, had immense paperwork demands on both the client and the provider, and often took very long to achieve while, in the mean time, the client was not receiving treatment. Integration in the transformed system would have much more integration between programs and services. Primary care and mental health would be in one facility, substance abuse treatment and mental health services would be combined, and different services, such as clubhouses and mental health programs would work together. There would also be increased communication between providers to streamline referrals and to aid in the treatment of clients being served in multiple settings for co-occurring afflictions.

- **Mental health in the education system** was mentioned often as a component needed in an integrated system. Ideally, educators would be trained to recognize mental health issues and would then have a network to refer these children for assessment and treatment if necessary. This prevention/early intervention approach was mentioned as a way to cut long-term costs in later mental health treatment if the problems could be identified and lessened early on.

- **Mental Health and the Justice System** was a common topic. Officers are often asked to make a judgment call about a mental health issue of a suspect often without proper knowledge of mental health and often without options for diversion even if they suspect mental illness. Once incarcerated, mentally ill offenders do not have much access to treatment. The offender either serves time or is released (often mentally ill offenders are released early because of their issue) and because there was no treatment or assessment, they return to the streets instead of a mental health program and more often than not, they become repeat offenders and the cycle continues. The education of diversion from prison and training on the part of the officers and the criminal justice system was noted as improving, but is still an area of concern that needs to change.

- **Services Needed.** Improvements and additional availability of specific services and program components were frequently cited. Housing was the most frequently mentioned. Day treatment centers and day programs, more clubhouses, drop-in centers, respite, employment services, and wraparound programs were also mentioned. Transportation for mentally ill consumers was seen as necessary so that they could get to appointments.

- **Treatment Focus.** The way to approach treatment and mental illness was a frequent focus of testimony. The order of frequency of nominations was as follows: Prevention-Focused, consumer-driven, family integration, recovery-focused, culturally aware services, early intervention approach, evidence-based treatments, strengths-based approach, and also a number of others that were less frequently mentioned.

- In regards to **Treatment Professionals**, there is an overall lack of quality providers especially psychologists, psychiatrists, and case managers. Reasons for these issues are the low pay for mental health staff, low job satisfaction, high case loads, and unmanageable "red tape" causing turnover that affects the overall quality of treatment.

- **Stigma** was mentioned often as a problem. Educational efforts directed at the community aimed at the reduction of stigma were mentioned as a needed component and was also considered a marker of a transformed system.

- **Regional Discrepancies** were mentioned many times. Consumers and providers in smaller, rural areas are experiencing a lack of options for treatment as well as the inequality of government funding to smaller areas that increases the lack of options. Consumers must travel great distances to get to treatment centers and then may have to go even further to get services that actually fit their need. Equality in all areas of the state would be an indicator of a transformed system.

- **Outcomes** The most often mentioned outcomes of a transformed system were: Fewer mental health issues encountered in the criminal justice system, fewer mental health in ER and in primary care facilities, reduced homelessness of mentally ill individuals, increased consumer satisfaction, easier access to care, higher employment rates for mentally ill, reduction of stigma, decreased recidivism, and reduction of crisis situations, as well as many others.

A full summary of all themes and statements for each of the four questions is presented in the Table on the following pages.

Table 1.
Results of qualitative analysis of public testimony included in the Additional Public Testimony report (N=2261 statements total).

Themes	N Statements
What is working well?	**335**
Mental Health Services	**152**
General Services/Program Types/Facilities	**110**
Clubhouses	21
Peer-to-Peer Programs	12
Immediate Crisis Services are Available When Needed	10
Community Mental Health Centers	9
Law Enforcement Can Easily Transfer Mental Health Issues to a MHP	6
Residences/Housing/Transitional Housing	6
Access to Care is Improving but Not Necessarily "Working Well"	6
Mental Health Services in Jails is Better	6
Vocational and Educational Programs	5
Triage Centers	5
Mental Health System and Services in General	5
Transitional Services after Leaving Jail	4
Private Mental Health Services are Great but Very Costly to the Consumer	4
Quality of Care Continues to Improve	3
Outreach in Smaller Communities	2
Vocational Services	2
Involuntary Treatment Act	2
Smooth Transitions to Hospitals When Beds are Available	1
Co-Located Mental Health and Primary Care Facilities	1
Mental Health Services/Programs Specific Examples	**57**
Mental Health Court	6
NAMI	6
Crisis Hotlines	5
Harvest House	5

Themes	N Statements
Ombudsmen Program	4
Rainbow House	4
Catholic Family Services	3
State Hospital Access to Services	3
FPS	3
Dr. Court	3
MIKA	2
PCAP	2
EPIC	2
YAR	2
Safety Centers	1
PACT	1
Ridgefield Living	1
Purdy Women's Correctional Facility	1
DMIO	1
Day Treatment at WSH	1
Emergency Preparedness and Mental Health	1
Treatment Practices	**99**
Treatment Professionals	**48**
Dedicated and Committed People	17
Well-Trained and Knowledgeable Providers	9
Flexible and Willing to Work with Clients	6
Access to Psychiatrists for Consultation	5
Mental Health Professionals Available in Emergency Room to Assist Physicians	5
Positive Attitudes and Collaboration with Other Agencies	4
Culturally Diverse Service Providers	2
General Practices	**16**
Consumer-Driven Treatment	6
DBT Really Does Work	3
Access to Medications (if you can get to a psychiatrist)	2

Themes	N Statements
Transitional Services to Keep People from Being Homeless	2
Immediate Access to Care for Children in Foster Care Network	2
Increased Time Spent with Direct Care Providers	1
Integration and Collaboration of Resources	**11**
Improving	11
Integrated Programs (not just mental health issues)	3
Treatment Focus/Emphasis	**6**
Recovery-Based Approach	3
WRAPAROUND Approach	3
Funding	**36**
If you have Medicaid or Private Pay, Services Working Well	17
State Funding has Increased	10
Capitated Funding is Stable Stream for Agencies	6
Efforts to Find New, Flexible Funding Streams	3
Nothing Is Working	**25**
Miscellaneous Comments	**12**
Ads About Mental Health in Newspapers	3
Depression Ads on TV	3
State has Begun to Show Support for Mental Health	2
Complaints Resolved at Lowest Possible Levels	1
Ombuds and Providers Work Well Together	1
Facilities at State Hospitals are Adequate (libraries, meals, activities)	2
Education/Training Programs	**11**
Substance Abuse Education in Justice System	4
Police Getting Better at Identifying Mental Health Issues	4
Consumer Networking	2
Consumers Need to Know How to Contact Ombuds with Concerns	1

Themes	N Statements

Themes	N Statements
What is NOT working well?	**751**
Treatment Practices and Delivery of Service	**285**
Programs and Services	**127**
Not Enough Child/Adolescent Specific Treatment Options	11
Poor Case Management	10
Lack of Hospital Beds	12
Only Manage on a Crisis Basis	8
Community Mental Health Centers Resources Don't Meet Needs	8
Not Enough Safe Places to House Patients During Crisis	8
Lack of Follow-Through Services	7
Lack of Early Intervention	7
Poor Medication Follow-Up and Tracking of Side-Effects	6
Services for Homeless Not Working	6
Too Much Use of Medications Solely	6
Lack of Counseling for Youth, Young Couples, Families	5
Lack of Prevention-Based Approach	5
Health and Wellness Based Programs Not Available	5
Cannot be Individualized/Tailored	4
Poor Retention Rates	4
Always Changing Because of Unpredictable Funding	3
Value-Based Instead of Scientifically-Based Treatments	3
Commitment Procedures and Practices Do Not Work	2
Treatment in State Hospitals Not Quality	2
Discharge Process Too Difficult and Takes Too Long	2
Not Enough Relapse Prevention for Offenders - Revolving Door	1
Not Enough Options for Long-Term Care	1
State Wants Outreach/In-Home Treatment but Doesn't Recognize Associated Costs	1

Themes	N Statements
Treatment Providers	**103**
Not Enough Clinicians (Psychiatrists and Psychologists)	24
Unmanageable Case Loads	20
Treatment Providers Not Trained Very Well	17
High Staff Turnover	15
Not Enough Case Workers	12
Burned Out Staff	10
Don't Treat the Consumers Well (like human beings)	4
Can't Bill for Services	1
Integration/Collaboration	**55**
Lack of Integration and Collaboration of Services and Programs	23
Not Enough Communication Between Providers	12
Poor Practices for Co-Occurring Conditions	12
Ping-Pong Effect to Clients	8
Mental Health System (general)	**247**
Barriers to Care	**165**
Access to Care Difficult	39
Takes Too Long to Get Services	29
Need To Address Rural Areas and Their Limitations/Lack of Facilities	25
Bureaucracy/Too Many Regulations - Conflicting and Constantly Changing	20
Unmanageable Paperwork Requirements	19
Too Many Mentally Ill Using Hospitals and Prisons for Treatment	12
Too Many Mentally Ill Having to get Treatment From Primary Care	9
Too Many Gaps – People Get No Services	8
Eligibility for VA Housing is too Strict/Unrealistic	3
SSL Applications are Discriminatory	1
General	**82**
Resources Do Not Meet Demand	23
Too Much Stigma	20
System Not Sensitive to Children - Based on Adult Mental Health Model	15

Themes	N Statements
Whole System Working Poorly	12
HIPAA	7
County System Doesn't Care About the Consumers	4
State Has Not Provided Clear Direction for the System's Development	1
Funding	**171**
Consumer Related	**85**
Lack of Services for Non-Medicaid and Non-Private Pay Clients	39
Access to Medications and Funding for Medications	18
Inflexibility of Use for Consumers	12
Treatment Access Because of Increased Diagnostic Criteria Strictness	8
Medicaid D Cuts Medications and Coverage	5
Private Mental Health Service is Inaccessible to Many Consumers	2
Insurance System for Longer-Term Care Situations	1
System (General or as a Whole)	**54**
Lack of Funding Across the Board	19
State Fails to Recognize Rural Areas/Funding Issues	13
Bureaucracy Costs Taking Funds from Treatment	11
Money-Driven System instead of Need-Driven	9
Inadequate Distribution	2
Program and Provider Related	**32**
Instability of Programs Due to Funding Being Unstable	15
Treatment Staff Not Paid Well	12
Funding Cuts to Outpatient Treatment Centers	5
Requirements Too Rigid to Tailor to Needs of Consumer	4
Consumer-Related Issues	**44**
Consumers Don't Know What is Available or How to Access It	10
Limited Access to a Psychiatrist	8
Not Enough Support for Family Members Trying to Help Mentally Ill	7
Consumers Don't Know Their Rights	5
Not Working Well With Minority Consumers	5

Themes	N Statements
Don't Have Enough Time with Therapists (non-MA level)	3
Children and Families Have the Hardest Time Getting Treatment	3
No Options Besides Behavioral Health Office	2
Some Consumers Don't Know How to Contact Ombuds	1

Themes	N Statements
What will a *transformed* system look like?	**821**
Treatment Services and Programs	**394**
Integration and Collaboration	**116**
More Integration and Collaboration of Services	44
Facilities for Co-Occurring Disorders - MH/SA and Primary Care in One Facility	30
Communication Between Professionals	17
Mental Health Community and Education System	13
Mental Health Treatment in the Justice System	12
Access To Care	**104**
Easier Access for All Consumers Seeking Care	31
Streamlined and Smooth Access to Care	27
Better Access for Non-Medicaid	19
Access for Everyone	15
Easier Access to Medications	12
Treatment Practices	**43**
Continuity of Care	18
Individualized and Tailored	11
Screening for Maternal Depression	4
Increased Flexibility/Adaptability	4
Stop Forcing Medications and Psychiatry on People	3
Ongoing Review and Case Management	2
All Agencies Have Access to SAHMSA Resources	1
Treatment Professionals	**55**
More Counselors/Case Workers	15

Themes	N Statements
More Psychiatrists	11
Lower Case Loads	9
MIS System for RSN's and Other Providers to Streamline Transitions	8
Need for Bilingual/Multicultural Counselors and Professionals	4
Professionals Trained to Treat Co-Occurring Disorders	4
Crisis Intervention Teams	2
In-Home Treatments	2
Bureaucracy and Regulations	**25**
Less Paperwork	14
Less Bureaucracy - Revise the WAC's	11
Additional Services Needed or Improved	**201**
Housing	29
Employment Services	16
Day Treatment Centers/Day Programs	14
More Clubhouses	12
More Mental Health Services in Jails	12
Drop-In Centers/Respite Centers	11
Transportation	10
Social and Recreational Activities for Consumers in Treatment Centers	10
Outreach and Engagement Efforts	10
Transitional Services in Place	8
Places to Go Other Than ER and Jail	7
Wraparound Services Needed	7
Hospitalizations (Beds) Available When Needed	6
Greater Array of Services/Choices	6
Foster Homes (Therapeutic)	6
Diversion Facility to Keep People With Mental Illness Out of Jails/Hospitals	6
Mental Health Awareness and Programs in the Educational System	5
Educational Services	4
In-Home Treatments	3

Themes	N Statements
Group Living Situations Not Individuals Alone	3
Veterans Homes and Other Services for Veterans Specifically	3
Catalog of Services With Criteria and Contacts	2
Crisis Lines Better	2
Emergency Mental Health Care Facilities Not the Hospital ER's	2
Community Outpatient Facilities	2
More Counseling Services	2
Parenting Education	1
Assisted Living	1
Follow-Up Services	1
Treatment Focus	**102**
Prevention-Focused	16
Consumer-Driven	13
Family Counseling Services/Family Integration	10
Recovery-Based	9
Cultural Awareness Emphasis	9
Early Intervention Approach	9
Evidence-Based Treatment	9
Strength-Based Approach	6
Age Awareness/No Neglecting of Younger or Older Populations	6
Client-Focused Approach	5
Community Treatment Approach	4
Peer-to-Peer Consumer-Driven Treatments	3
Holistic Approach to Treatment	2
Trauma-Centered Care	1
Funding/ Use of Funds	**76**
Non-Medicaid Funding	17
Increased Pay for Mental Health Staff	13
More Funding Across the Board	11
Flexible and Integrated Funding Options	11

Themes	N Statements
Money Follows the Client Not the Agency/Programs	6
Stable	5
Do Not Lose Funding in Jail	5
Medication Support	2
College Campus Mental Health Centers	1
More Informed Provider Network	1
Funding for Post-Partum Depression Extended	1
Go Beyond the Medicaid Minimum and Provide What is Actually Needed for Success	1
Funding for Immigrants to Get Mental Health Services	1
More Funding for Special Education Program In Schools	1
Training and Education	**65**
Consumer-Focused Education Efforts/Integrated Education into Existing Programs	13
Educate the Community (general public, schools, etc.)	11
Educate Police Officers About Mental Illness to Aid Diversion	11
Staff Trainings	11
Treatment Professionals in General	7
Social Skills Training for Consumers	5
Medications, How to Get Them, Side Effects (to the consumer)	3
Train the Families About Mental Health and How to Help	2
Mental Health Professionals About Chemical Dependency and Vice-Versa	1
Conferences About Holistic/Other Alternatives to Current Treatment	1
Entire MH System	**34**
Consistent Policies and Procedures (not different for each RSN)	11
Stability	8
Regional Services - Closer to Home, More Accessible	6
No RSN Network	5
Evaluations Before Crisis	2
State Would Actually Support Mental Health System	2

Themes	N Statements

Themes	N Statements
Outcomes of a *transformed* system	**354**
Outcome Measures	**354**
Consumer-Related	**255**
Fewer Mental Health Cases in Justice System/Less Jail Time for Mental Illness Issue	40
Fewer Mental Health Hospital Visits/Hospital stays	33
Reduced Homelessness	27
Consumer Satisfaction Increased	25
Increased Access to Care	22
Employment Rates Following Treatment	19
Reduction of Stigma	18
Decreased Recidivism	11
Greater Access to Medications and How to Pay for Them	9
Reduce Crisis Situations	7
Home and Social Stability After Release	6
Fewer Involuntary Commitments/Incarcerations for Mental Health Issues	6
Consumers Set Their Own Goals	5
Use the GAF as a Result Assessment	5
Reduction of Suicide Rates	5
Consumer Representation in Government	4
More Interaction with Psychiatrist	4
Returning to/Seeking Further Education After Treatment	3
Fewer People in Acute Care Situations	2
School Children are Less Disruptive and Attend School More Often	2
Better Educational Performance After Treatment (mainly children)	1
Decreased Deaths for Homeless Mental Illness	1
Services and Treatment	**68**
Timely Treatment	13
Higher Provider Job Satisfaction	9

Themes	N Statements
Housing	8
Well-Trained Workforce	8
Smaller Case Loads	7
Better Retention rate	6
At-Home Treatment Services	6
24 Hour Availability	3
Strength-Based	2
More Regular Mental Health Treatment	2
Better Assessments	1
Less Diagnosis Handed Out	1
Transitional Services and Supervision of Transitions	1
Need for Services is Met Not Higher Than Those Provided	1
Funding	**31**
Treatment for those non-Medicaid	9
Flexible funding	6
Adequate stable funding	6
If you qualify, you get quality, timely treatment	5
Reduced Administrative Overhead	3
Clients do not lose funding if they go to jail	1
Decreased Cost per Client/Cost per Service Hour	1

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ADDITIONAL PUBLIC INPUT

Selected Representative Quotes

System as a Whole Working Poorly

"As hinted in the president's commission report, there is something fundamentally wrong with a system that takes the most complicated medical conditions such as schizophrenia, borderline personality disorder, bipolar affective disorder, addictions, etc. out of the health system and puts them in state or local government bureaucracies with very limited budgets. It is hard to imagine a Division of Cancer Treatment in DSHS where patients diagnosed with cancer have to leave their medical centers and enroll in special cancer agencies in order to get their cancer care staffed by providers with less training and for drastically less money than they would have gotten if they had been diagnosed with heart disease and stayed in the medical system."

Access to Care – Quality of Care

"What is not working in our community is lack of access for people needing services, lack of services, lack of services that properly address mental illness. We have seen emphasis on behavioral changes for individuals, behavioral changes for family, behavioral changes for children without in some cases adequate diagnosis, treatment plan, case management, medication management. And what this translates to is less than adequate treatment of a significant biochemical imbalance of the brain."

Access for Non-Medicaid Qualifiers

"Access to services and treatment for those without Medicaid is very difficult and not equal – some RSN (KingCo in particular) has virtually no capacity to provide outpatient health services if the person does not have Medicaid."

Too Many People Receiving Treatment by Primary Care Physicians and ER

"Many low-income people end up seeking and receiving mental health services through their primary care providers at community health centers, because that is the only avenue available to them. Family practice physicians, nurse practitioners and physician assistants are stretched beyond their scope of practice to prescribe and monitor psychiatric medications, because there is no where else for patients to receive this service."

Treatment Providers in Jails – Transitions Out of Prison in Place

"If there were ADATSA counselors at the prisons, then the offenders could go directly from prison to inpatient treatment centers. Maybe the CD treatment center has a discharge planner. The folks who need inpatient CD treatment the most are the mentally ill offenders who continue to re-offend. These offenders are homeless, do not have SSI or a medical coupon, are committing crimes to continue their drug habits. Why doesn't someone stop this awful cycle by allowing ADATSA counselors into the prisons?"

Treatment Providers in Jails

"How someone becomes mentally disabled creates the structure and method in which they are treated. Crime caused by mental disability is still crime and clearly must be addressed. Corrections facilities should consider being treatment facilities as well as part of total corrections and education programs."

Integration and Collaboration

"The RSN and non-RSN parts of the mental health service structure would be well integrated. Mental health issues are very interrelated. Homeless mental health is tied to chemical dependency, life skills, and Veterans issues – they cannot be looked at in isolation. The structure of service delivery is not nearly as well integrated as the nature of the problems."

Integration and Collaboration – Communication between Providers

"There is no commonly accepted framework or language for describing mental health services delivery structure that efficiently and effectively communicates what is available and where their are gaps."

Integration and Collaboration

"I see the need for the state funded mental health team to be integrated with the local health care teams. I do not think that having only a freestanding mental health facility is going to be adequate. Most of the patients that are seen for mental health disorders are seen because of co-morbidities, preventive health measures, or other reasons that they come to a health care provider. Unless there is a significant amount of integration and coordination of this care, we will always be battling inadequate access, inadequate supply due to the lack of capacity planning, therefore running the risk of either inadequate capacity, which we have now, or duplication of services elevating the direct cost of care unnecessarily."

Too Much Bureaucracy – Administrative Costs Detract from Treatment

"The state and federal governments continue to increase administrative burden in managing the system, much of which does not contribute of more or better care for consumers. These increased costs have not been covered by increased revenue, but instead there is pressure to reduce administrative expenses."

Unmanageable Paperwork Requirements

"In addition, the paperwork requirements for therapists providing services are so daunting that they cannot see many clients. The face-to-face percentage requirements at our agency are kept at 50% specifically because of the paperwork. Having worked in other states, I know that I could see many more clients than 20 out of a 40 hour work week. So, we could provide services to more people if the paperwork was less. What happens is that therapists get burned out quickly because of the paper demands and then the low pay. This agency has difficulty maintaining quality counselors due to the extremely low pay. I, myself, could qualify for this county's sliding fee scale because of my low income."

Unmanageable Paperwork – Only Serve in Crisis – Staff Wages – Staff Turnover

"Given the limited funding of public mental health services, caseloads (at least in King County) are incredibly high and the paperwork work load so overwhelming that many patients with severe illnesses are seen as little as monthly and often only to complete needed paperwork. Clinical care is often provided only when a client calls in crisis leading to chaotic schedules for clinicians and chaotic treatment ebbing and flowing for clients. Case managers are paid very little money. With the above job stress and lack of training there is such frequent turnover that it appears that many provider agencies don't even try and invest in training as their staff are likely to leave in 4-12 months. Such turnover for clients with severe illnesses lasting years to decades is unconscionable."

Increased Treatment Staff Wages

"Funding would be consistent with the desired educational levels of service providers and staff members would be treated as professionals, in terms of financial compensation and basic respect. The federal government and the state would stop treating providers of social and human services as second class citizens."

Funding Causes Program Instability – Need Stable Funding Streams

"There continues to be a fickle system of funding which ensures instability in programs that provide critical services. Programs are forced to continually shift and change due to an unpredictable funding base."

Lack of Funding and Resources

"Lack of adequate funding for public services. In outpatient work this means frequency & duration of treatment is not based truly on client needs and clinical assessment but on level of care guidelines geared to manage scarce resources. It means that a population who have experienced trauma of many kinds, but particularly around human attachment, are re-traumatized again and again because they can be provided only with crisis services, and no durable trustworthy bonds. It means therapists are stressed by doing harm to already vulnerable clients."

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REGIONAL SUPPORT NETWORK INPUT
April 4, 2006

Introduction

The current report represents an analysis of the content of feedback to the Washington State Mental Health Transformation (MHT) effort from the state's Regional Support Networks (RSNs). Responses received from RSNs were typically summaries of input from multiple stakeholders surveyed by each RSN. These sources included advisory group members, consumers, providers, and other stakeholders. A small amount of input was received in the form of feedback from individuals associated with RSN's.

Method

Across the sources of data listed above, information received and analyzed were responses to a consistent set of 4 open-ended questions posed to individuals statewide:

1. Within Washington State, and for all mental health services, public or private, what is working well when addressing the needs of mental health consumers?
2. Within Washington State, and for all mental health services, public or private, what is NOT working, creates barriers or fails to provide quality service and support when addressing the needs of mental health consumers?
3. What would a "transformed" mental health system look like?
4. What outcomes would indicate that the changes in the mental health service systems are creating improved results for consumers?

Data were received from the state MHT team in the form of listening session transcripts, meeting summaries, reports, letters, email and web surveys forwarded from RSN representatives or constituents, and Adobe Acrobat "PDF" files of handwritten testimony. A team of PhD-level researchers then conducted qualitative analysis of these raw data using a technique described by Marshall & Rossman (1989). First, unique statements were isolated and summarized from all individual testimonials received. Next, categories were created and all statements sorted by these categories. Third, new categories were created for statements that did not fit the initial categories. Finally, small categories were sorted into primary categories.

To increase ease of use and interpretation, a single analysis of all statements was conducted. However, this report also includes a Table with responses broken out by all four questions. The purpose of the report is to provide Subcommittee members and others working on the mental health transformation project a record of all the public feedback received that is relevant to this Subcommittee, organized in a way that allows for observation of the relative amount of testimony provided within each topic area, and discussion of priorities for action.

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The current report

The current report consists of three main sections.

- The first section presents an **overview** of the analysis, including data sources and total number of unique statements coded. This section also includes a brief narrative summary of the findings.
- The second section presents the **results of qualitative analysis in detail**. This Table presents unique themes expressed in public testimony for each of the 4 Mental Health Transformation questions, organized by primary and secondary categories. For each unique theme, the number of statements that were found in the data related to that theme is presented. It is hoped that this Table will be a useful reference for reviewing the priorities presented by the RSNs.
- The third section presents a selection of **direct statements and quotes** from the meeting transcripts and other information received, grouped by major themes.

Acknowledgments

Data analysis for the Mental Health Transformation Public Testimony Summary and Analysis Reports was conducted by:

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WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Summary and Analysis

REGIONAL SUPPORT NETWORK INPUT

Data sources:

1. 9 RSN Summaries/Reports
2. 3 submissions from individuals associated with RSNs

Total Statements coded = 405

Summary of findings

RSN Input consisted of 405 unique statements coded from 12 submitted documents. Seventy-eight statements were coded from responses to the question "What is working well," 127 statements were coded from responses to the question "What is not working well," 156 statements were related to the question about what a transformed system will look like, and 44 comments were coded regarding proposed outcomes of a transformed mental health system.

A brief summary of the results across the four questions is provided below:

- **Integration and Collaboration of Services** is an area RSN's feel is being done well at the present but has also been labeled as an area of concern that needs to be addressed in a transformed system. The general consent is that integration is improving but needs to be further stressed since it does not happen consistently.

- **Access to Care:** although noted as an area that is improving, access is still one of the key problems of the mental health system and an area that needs to be significantly changed. Access is related to many factors including funding issues, eligibility issues, need surpassing resources, and other factors as well.

- **Funding** is generally viewed as an area that is not working and needs to be addressed. The most common area of concern is Medicaid and its limitation in terms of eligibility and flexibility. The lack of options other than Medicaid is also a concern. Increased flexibility and increased options, other than Medicaid, should be included in a transformed system.

- **Bureaucracy** was noted as a barrier to treatment because of a number of reasons: constantly changing rules and regulations, too many rules, unmanageable paperwork, and high administrative costs that ultimately affect the level of care and the availability of care to the consumer.

- **Treatment Provider Factors.** Positive statements about treatment providers included their dedication and willingness to help. The negative is that there is a shortage of psychologists and psychiatrists in most areas, particularly in smaller regions, and their

case loads are unmanageable. This fact, combined with inadequate pay, causes a great deal of staff turnover which ultimately disrupts the client.

- **Recommendations for a Transformed System** typically paralleled the previously mentioned issues. There is a need for flexible funding, for options other than Medicaid, for less bureaucracy and paperwork, for lower case loads, for better state government-level management from MHD, and for a number of services that either need to be added, expanded, or improved upon from the current system.

- **Additional Services.** Primary among the services cited as being needed included housing, employment services, day treatment, Wraparound, transitional services, crisis centers, and age-specific services and programs.

- **Outcomes.** Although diverse in nature, client-related outcomes were nominated more often than system or treatment outcomes. Client-related outcomes that were nominated included a reduction in homelessness, recidivism, hospital use by mental health clients, and diversion from the criminal justice system.

A full summary of all themes and statements for each of the four questions is presented in the Table on the following pages.

Table 1.
Results of qualitative analysis of public testimony for the Older Adults Subcommittee (N=405 statements total).

Themes	N Statements
What is working well?	**78**
Mental Health System (General)	**24**
Mental Health Services that are working well (Specific Examples)	**17**
Promise Club	3
Peer-to-Peer Programs	2
Drop-In Centers	2
Permanent Housing for Homeless Mentally Ill Population	2
Crisis Prevention Programs	2
Dangerous Mentally Ill Offenders (DMIO)	1
Day Treatment Programs/Safe Havens	1
PATH Programs	1
King County Treatment Courts	1
ACT teams outreach	1
NAMI	1
General System Examples	**7**
Improved Diversion Practices (those with mental health issues not going to jail as often)	3
Committed and Dedicated Providers and Programs	2
Services are Easy to Access	1
Reduction in Recidivism for Juvenile Offenders with MH/SA Issues	1
Efforts to Reduce Homelessness	1
Collaboration and Integration	**21**
Across Programs and Services/Between Providers and Professionals	12
Mental Health and Medical Community/Doctor's Services	3
Mental Health Courts are Providing Mental Health Treatment, Not Just Incarceration	2
Law Enforcement More Aware of Mental Health Issues and Diversion	2
Between Agencies and RSN's	1
Combined Housing and Mental Health Care Services	1

Funding	11
Free Access With a Coupon (in theory)	3
Funds For Offenders Leaving Detention to Get Services and Housing/Food	2
Multiple Sources of Funding	1
Funding for Youth Transition Programs	1
Funding for Co-Occurring Disorder Initiatives	1
Funding for Homelessness Programs	1
Flexible Funding Not Tied to Medicaid is Increasing	1
Dependable Funding Stream to Agencies	1
Treatment Practices	**11**
Services that are Culturally Aware	3
Evidence-Based Practices are Working Well	1
MST	1
FFT	1
SRT	1
JRA	1
Support Groups	1
Counseling for Non-Severe Mental Health Diagnosis is Good	1
Treatment Professionals	**7**
Access to/and Frequent Consultations with Psychiatrists	3
Liaisons that Connect Youth with Substance Abuse Counselors	1
Acute Treatment in ER's from Mental Health Professionals	1
Dually Certified Professionals in Mental Health and Substance Abuse	1
Mental Health Professionals are Available to Hospitals and Jails in Crisis Situations	1
Miscellaneous Remarks	**4**
The Stakeholders Group	2
Legislators More Aware of Mental Health Issues in Criminal Populations	1
Depression Commercials on TV	1

Themes	N Statements
What is NOT working well?	**127**
Funding	**38**
Government Funding of MH in WA	**17**
Medicaid Funding is Too Limited in What It Will and Will NOT Fund	4
Requirements for Funding Eligibility Always Changing	4
Government Funding Barriers (SSI, GAU, etc)	3
Resources are Inadequate to Meet Need	2
Inconsistent/Unstable Funding	2
Funds Not Fairly Distributed Among RSN's	1
Consumer-Related	**17**
Coupons Not Flexible	8
No Options Without Medicaid Eligibility	7
Cost of Medications	2
Provider/Services Related	**4**
Siloing/Compartmentalizing/Inflexible Funds	3
No Funding for Training (NAMI)	1
Treatment Providers	**36**
Regionally Limited	7
Lack of Providers (Psychiatrists and Psychologists)	5
Unreasonable Paperwork Demands	5
Long Wait Times to Get Into Services	4
Not Enough Beds in Hospitals/Involuntary Treatment Placements	3
Case Loads Too High	3
Intake Repeated at Each Referral/Change of Provider	2
High Turnover Rates Among Employees	2
Staffing is Inadequate to Meet Demand and Need of Consumers	2
Peer Support Training Not Accessible Enough	1
BHO Refusing to Provide Service	1
Chelan/Douglas MH is Overwhelmed for its Resources	1
Treatment Practices	**23**

Access to Care	11
Too Many People Getting Mental Health Care in ER	3
Access to Hospital Care When Needed	2
Culturally Aware Mental Health Services/Treatments	2
Too Many Consumers Falling Between the Cracks/Unintentionally "Dumped"	2
Not enough Emphasis On Recovery - Only Recidivism Reduction	1
Too Few Youth and Adolescent Services	1
Inability to Provide Individualized/Tailored Care	1
Mental Health System As A Whole	**21**
Bureaucracy	4
Housing Not Available	3
Constantly Changing Rules and Requirements	3
All Under Different Governing Bodies (WAC, etc.)	3
MHD Not an Adequate Leader and Does Not Work Well with RSN's	3
Not Enough Resources to Meet the Need of Emotional Care	2
RSN Requirements Don't Match WAC	1
Failed to Facilitate Recovery	1
Employment Programs Not Available/Not Effective	1
Integration/Collaboration/Communication	**9**
Lack of Integration Between Treatment Services and Providers	4
Lack of Connecting Released/Incarcerated Offenders to Community Resources	2
Privacy Laws Hinder Information Sharing Across Programs	1
DMIO is Not Connected to DASA but 80%+ Have Co-Occurring Mental Health and Substance Abuse	1
No Continuity of Service	1

Themes	N Statements
What does a *transformed* system look like?	**156**
Treatment Practices	**33**
Programs and Services	**21**
Access to Care/No Wrong Door	6
Reduction of stigma	5
Manageable Paperwork	4
Increase Diversion	2
Peer Supports and Person-Centered Planning	1
Treating the Whole Person Not Just Mental Health Issue	1
Early Assessment in Schools	1
Reduce the WAC Laws and Rules	1
Treatment Professionals	**12**
Mental Health Professionals Available 24 Hours at Justice Centers	2
Readily Available Mental Health Professionals (therapists, psychiatrists)	2
Standardized RSN Management Practices	2
DSHS has Fewer Administrations	1
Don't Want Master's Level Therapists Who Aren't Trained Adequately	1
Professional Diagnosis	1
Better Informed Leadership	1
Better Case Management	1
Psychiatrists	1
Treatment Focus/Approach	**29**
Cultural Awareness	5
Prevention Focus	4
Family-Centered	4
Recovery-Based	3
Evidence-Based Treatment	3
Strength-Based	2
Consumer-Driven	2
Holistic Approach	2

Early Assessment and Identification	1
Community-Based Mental Health Treatment	1
Relationship-Based	1
Funding/ Use of Funds	**25**
Flexible Funds	9
Alternative Funding Sources Other Than Medicaid	2
Revisit Reimbursement Model	2
Stable and Adequate Funding	2
Eliminate Categorical Funding	2
Staff Wages Appropriate to Education/Raised In General	2
For Educational and Training Programs	2
Easier Access to Government Funded Programs	1
Medicare "D" Program	1
Consumer Shared Cost Based on Ability to Pay	1
Streamlined/Universal Payment Methods Process	1
Services	**22**
Crisis Centers/Crisis Interventions	4
Wraparound	3
Age Specific Programs	3
Therapeutic Care in Schools	2
School-Based Case Management/Assessments	2
Change JRA - Not Stand Alone Department	1
SA/MH/DD Should Be One Unit	1
Coordination of Care	1
Residential Care Facility	1
In-Home Treatment Services	1
Assessment for Mental Health Done in Justice System	1
Co-Occurring Disorders Programs	1
Peer Counselors	1
Integration/Collaboration	**19**
Better Integration of Services	7

Integration and Blending of Funds Across Programs	3
MIS System to Streamline Transitions and Referrals	3
Integrate Mental Health Providers into the Medical Health Teams	3
School System Involvement	2
Criminal Mental Health Population Get Connected to Community Services	1
Training	**16**
General Training About Mental Health Treatment	4
Teach Consumers How to Effect Their Own Treatment	2
Educating Primary Care Physicians	2
Law Enforcement Taught About Mental Health and Service Alternatives to Jail	2
Peer Support Training Changed and Supported Better	2
Recovery Education Campaign	1
For Consumers About Medications	1
Clinicians are Well-Trained About Prevention	1
First Responders Trained In Mental Health Issues	1
Additional Services	**12**
Housing Programs	4
Employment Supports	3
Day Treatment Programs	3
For Homeless Youths Not in Families	1
Transition to Secondary Education Initiatives	1

Themes	N Statements
Outcomes of a *transformed* System	**44**
Outcome Measures	**44**
Client-Related Outcomes	**20**
Reduced Homelessness	4
Reduced Recidivism	3
Diversion from Hospitals	3
Less School Suspensions	2
More People Accessing Resources	2
Reduce Need for Mental Health Involvement in Justice System - Diversion	2
Reduction in Disruptive Classroom Behaviors	1
Increased Academic Achievement	1
Reduced Drop-Out Rate	1
Reduction in Suicide Rates	1
Mental Health System Outcomes	**9**
Measured Reduction in Mental Health Stigma	3
Seamless Transition Between Services and Upon Release from Jail	2
Rural Access to Mental Health Care	1
Use of the ROSI	1
One Data Collection System	1
Reduce Paperwork	1
Treatment and Service Outcomes	**15**
Working Definition of Recovery	1
Use of Advanced Directives	1
Use of Telesage Instrument	1
Reduction is Use of Restraints and Seclusions	1
Reduce Involuntary Commitments	1
More Consumer-Run Organizations	1
Recovery Program Development	1
MHD Standardized Service Delivery Expectations	1
Assessing Fidelity to the Recovery Model	1

Individualized and Tailored Care	1
Reduce Disparity between Consumers Needing and Receiving Treatment	1
Mental Health Disease Registry Measure	1
Reduction in Hospital Admissions for Mental Health	1
Less Medication	1
Diversion from Criminal Justice System	1

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis
REGIONAL SUPPORT NETWORKS REPORT

Selected Representative Quotes

Too Many People Getting Mental Health Care in ER/Primary Care

"I would estimate that the average Family Physician or Internist in our area is treating a patient for some level of mental or emotional illness 25-30% of the time, every day that they work in our outpatient facilities."

No Options Without Medicaid Eligibility

"Not all in need of mental health are eligible for medical coupons and, thus, go unserved."

Consumer-Driven Treatment Approach

"I believe it is important for the consumer to have goals of their own and take more ownership in their treatment. If they want family members and natural supports to help them, all the better. We should implement this by doing more wraparound-type services. Peer-to-peer treatment is invaluable, too. A peer that has been there before can really help one with the same or similar mental illness. Peer counseling is goal-driven which will empower the consumer in resiliency and recovery. Giving the consumer tools to use and encouragement and encouraging the consumer goes a long way in recovery."

Funding Issues – RSN Distribution

"Money not fairly distributed among RSN's (scored well on actuarial, lost state-only funding, consequently, flexibility of meeting needs of non-Medicaid consumers in need)."

Mental Health Professionals Available in Primary Care Facilities When Needed

"Mental health workers are very available in the event that we as Physicians or health care workers are confronted with patients in the emergency room or the acute setting who have the need for crisis intervention and possible hospitalization in that they are a harm to themselves, others, or unable to care for themselves."

MHD Inadequate Leader

"Totally inadequate leadership from MHD resulting in constantly changing requirements and expectations to the RSN. The end result of this lack of effective leadership is limited dollars being spent on bureaucracy that are not getting to patients who need services. Another result of this problem is that RSN's are left to try to respond to their providers the constantly changing rules and requirements. Providers are constantly trying to figure out what the issue is, how to deal with the issue and how to get services out to patients while trying to deal with the issue."

Overall Lack of Resources to Meet Needs

"As Physicians and a health care institution, in a word, this is access to emotional mental health care for any and all of the above mentioned seven population groups. There is simply **not nearly enough mental health capacity in Chelan/Douglas County to deal with even a small**

fraction of the need that we see. On a daily basis, Primary Care Physicians and Mid-level providers in our institution are dealing as best they can with patients who suffer from psychiatric disorders ranging from significant depression, bi-polar disorder, all the way to severe psychosis, schizophrenia and borderline personality disorder. They have taken on this role themselves because there is simply inadequate help."

Need for Flexible Funding Options

"Flexible dollars made available that providers could use to address needs such as housing, clothing and the basic needs that poor families must address in order to be successful in their mental health treatment and to move forward with their lives in a positive manner."

Police Trained to Identify Mental Illness - Diversion

"First responders such as law enforcement would be trained to work with the mentally ill in a way that reduces, rather than increases, the likelihood that behaviors will escalate to the point that the consumer must be restrained or arrested. Great strides in this direction have been made in our community with training provided to police officers."

Unmanageable Paperwork Requirements

"The paperwork requirements for our system of care in Chelan & Douglas Counties are incredibly cumbersome. People are walking away from receiving services because they cannot face all of the requirements due to their emotional positions. If we spent as much time trying to deal with individualized and tailored care for patients as we do with how do we meet the paperwork requirements it is my belief that more people could move forward in their lives."

Lack of Service Options – Access to Care

"We have no intermediate place to have children get mental health care treatment that isn't a hospital (danger to self or others) or home/community (this wasn't working or the child wouldn't have gotten into a crisis relating to his mental illness). There is no residential treatment facility for children--where they can have their behavior, meds, schooling supervised and help them toward recovery. INSTEAD we routinely use juvenile detention as the solution for lack of mental health services in our community. It is the stick being held over the heads of mentally ill children. Imagine telling someone who isn't doing well with their cancer that if they don't comply/get better, we will send him to jail!"

Mental Health Services and Awareness in Schools

"Our schools have failed to recognize and advocate for mentally ill children. While they should not be expected to provide treatment for the mental illness, they should be willing to cooperate with and put dollars towards providing a suitable and safe way for children disabled by their mental illness to get an education. Schools treat children who are disruptive due to mental illness in the same way that they treat children who have bad behavior because of poor decisions they make--suspension."